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ABSTRACT

Increasingly, health care providers, educators, social service personnel, mental health and juvenile justice professionals, and others recognize that the discrete services they provide cannot meet the complex needs of today's youth and families. This paper presents findings of a descriptive case study that explored the interorganizational problems and solutions of three school-based health centers. Data were gathered through document review; observation; and interviews with a total of 24 school personnel, superintendents and other district administrators, health center staff, and sponsoring agency directors and program liaisons. The three school-based health centers encountered three major challenges: developing and maintaining relationships, maintaining confidentiality, and managing the referral process. The paper offers five recommendations for improving school-based health services: (1) include role counseling or clinical social workers in the services offered; (2) assign broad titles to group counseling sessions; (3) establish an advisory board or council with a broad representative base; (4) establish regular meetings among key members of the school-based program, the principal, and school administrative team; and (5) provide consistent funding. The paper advocates a model of "mandated collaboration," which contains a range of voluntary choices within the mandated structure, or bottom-up reform with top-down support. The program encourages local collaboration within a structure that maintains broad state-mandated requirements. One figure is included. (Contains 103 references.) (LMI)

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SCHOOL-BASED HEALTH CENTERS:

INFORMING FUTURE SITE-BASED INTERAGENCY COLLABORATIVES

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Increasingly, health care providers, educators, social service personnel, mental health and juvenile justice professionals, and others recognize that the discrete services they provide cannot meet the complex needs of today's youth and families. We bear witness weekly to startling reports regarding the status of children, youth, and families in America in the areas of physical and mental health, educational achievement, housing and homelessness, crime and mortality. To our nation's shame, estimates of the number of children living in poverty now range from twenty to twenty-five percent. Those of us in the field no longer look to blame anyone, but to concentrate on finding, implementing, and evaluating long-term solutions that work. When I was a public school principal, I recognized that interagency collaboratives based in schools were one such solution.

My overarching goal in conducting this study of school-based health centers was to use them, as the title suggests, "to inform future site-based, interagency collaboratives". This idea came about as a result of my direct experience with a small, successful interagency collaborative while principal of a 600 student, inner city elementary school. Dealing with numerous students and families who had multiple and often complex needs that the school alone could not serve, I understood both the need and the value of such collaborative programs.

Student attendance was one area of my professional concern as a teacher and principal. Elementary and middle school-aged students often missed school because their parents/guardians took them out of school to go to the dental or health clinic, or to take care of other social service needs, which increasingly became all day activities. This student attendance problem, that I once experienced as a teacher with groups of thirty-plus students, I now experienced as a supervisor, this time with portions of whole school populations of 600 students and more. The

interagency, school-based social work program positively impacted student attendance at my school, as well as assisted parents with problems in ways that no one else and no other program in the school could.

It also made sense to me that a school might actually become the center of the community in which it sits as a result of interagency programs being co-located within the school. After funding for afterschool centers was cut, in the evenings, schools stood dark and empty, like desolate castles, prone to break-ins and thefts. Having a school open until late at night that could provide community residents access to physical and mental health services, tutorial and adult education programs, juvenile justice, housing, and social services, as well as recreational programs seemed a much better alternative. Hence, with these earlier experiences and beliefs uppermost in my mind, I decided to study the most prevalent and successful models of school-based collaboratives: comprehensive school-based health centers. I felt that lessons learned here might be applied to other interagency initiatives.

Thus, the purpose of this descriptive case study was to (a) provide an understanding of the complexities involved in the interagency collaboration of school-based health services, (b) to clarify the types of challenges encountered and strategies developed by agencies and schools as they endeavor to make interagency collaboratives work in schools, and (c) to develop a working definition of effective day-to-day collaboration. To this end, I conducted a multiple-site case study of three school-based health centers where I explored the interorganizational problems encountered and solutions derived by health agencies, schools and community organizations as they worked together to satisfy a variety of needs of students and their families. Empirical data gathered and analyzed from the vantage of practitioners can inform future school-based interagency collaboratives. The research questions guiding this study were:

(a) What are the challenges faced by schools and agencies as they seek to collaborate in establishing and maintaining school-based health centers?

(b) How do schools and agencies address these challenges?

(c) What are the implications of their experiences for establishing successful comprehensive school-based interagency collaboratives?

Relevant Literature

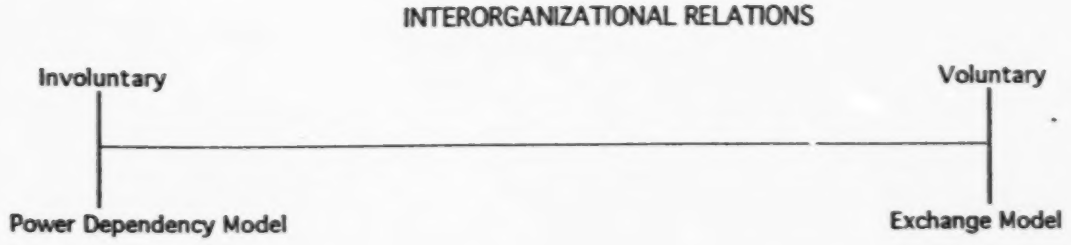
Four strands of literature were relevant to this study of the interorganizational issues faced by school-based health clinics and their host institutions, the public schools. These literatures dealt with (a) community schools/community education, (b) school-based health clinics, (c) interorganizational relations, and (d) interagency collaboration.

The interorganizational relations literature provided two theories used to analyze the various forms of interorganizational relations that might be found in studying the relationships between schools and school-based health centers. First, we can visualize the relationship of two organizations that are working together as falling on a *continuum of interaction* ranging from mandated to voluntary relations. That is, at one end fall those relationships called "power-dependency", identified by March and Simon in 1958. They argue that the motivation of organizations to interact is asymmetrical, in that only one organization sees the need for coordination. This type of relationship occurs most often in mandated interorganizational relations, where one organization has the "power" to force the other to cooperate (Schmidt & Kochan, 1977). For example, theoretically, a supra-agency such as a state could mandate placement of a health center in a school. However, according to the literature, such a move could jeopardize the health center's chances for success, because the types of interrelationships required for

interagency collaborations to function effectively "should [be] reorient[ed] away from the narrow dimensions of single agency mandates..." (Melaville, 1991, p. 9).

The more prevalent relationship, represented by Levine and White's (1961) exchange theory, falls toward the other end of the continuum. This theory suggests that two or more organizations voluntarily seek mutual benefits from their interaction, usually in times of scarce resources or performance distress (poor organization results) (Schermerhorn, 1975; Schmidt & Kochan, 1977). The exchange theory typifies the relationship espoused in most of the current interorganizational arrangements between schools, site-based health centers and their communities. The school is said to benefit from increased student attendance, achievement and school involvement (Clinic News, 1991; Siegel & Krieble, 1987), while the health center benefits by gaining increased access to a larger adolescent client base and the ability to provide comprehensive services to youth and their families (Klein & Sadowski, 1990). The community benefits by having two vitally important organizations functioning cooperatively to serve its needs. Furthermore, in the 1980's and now the 1990's, both schools and health agencies have had to deal with increasingly reduced budgets as well as "performance distress", in this case, the crisis in adolescent health care and the much debated decline in student achievement. Both organizations potentially gain from the mutual exchange of services.

FIGURE I. CONTINUUM OF INTERACTION



Within this exchange model, analysts have identified alternative approaches by which organizations work together. According to Intriligator (1983), interorganizational relations may be regarded as cooperatives, collaboratives, consortia, and/or coalitions. Importantly, these approaches imply different levels of coordination with regard to planning, organizing, and implementing activities. Kirst (1991) notes that, "Coordination of services enables each agency to be more effective while maintaining administrative and programmatic autonomy" (p. 617). Collaboration, however, is the approach that requires the most coordination, and according to the literature, holds the most promise for lasting change in the delivery of comprehensive services to students and families (Kirst, 1991; Hord, 1986).

Pilot Study

In addition to the literature, to further inform my understanding of the issues facing school-based health centers, and because very little research had been conducted concerning the organizational issues of school-based health centers, I conducted a pilot study which served to refine my research questions and provide an empirical balance to the literature reviewed. I also needed to gain a better understanding of the impact that important interorganizational issues had regarding topics such as the background and history of the centers, confidentiality, referral procedures, and roles and relationships. I conducted eleven in-depth, open-ended interviews with health center staff, principals and agency staff in three urban high schools. Each center had been in operation for three to five years. All were functioning successfully as judged by the percentage of the school population registered with the centers, number of appointments kept, and outreach to students without a primary care physician.

The pilot study revealed that after acute care, mental health counseling was the most requested service provided by the health centers, a fact also borne out in

the literature (Access, 1992; Elders, 1992; Kirby, 1986; Siegel & Krieble, 1987). Common concerns emerged at each center. For example: Should the health center withhold confidential information from school officials in all situations? How does the center come to know school policies? What can center staff do to increase referrals, from school personnel as well as from students themselves? Differences found among the health centers included the types of sponsoring agencies, number and types of services provided, referral procedures, on/off-site managers, and funding sources.

Some of the major concerns of interviewees that emerged from the pilot study were the need for building relationships, the gray areas of authority and accountability, conflicting expectations about confidentiality, developing an effective referral process, and dealing with the philosophical differences that exist between the professions of education and health care. I used these concerns to further refine the interview questions and expand my document review (Merriam, 1991; Yin, 1989).

With regard to the continuum of interaction, the formal health center and school relationships at all three pilot sites fell near the voluntary end, exemplifying Levine and White's exchange theory. The host schools and the sponsors of the health centers entered into these collaborative projects voluntarily. Interviewees noted the benefits received from these voluntary relationships. Schools gained by having healthier students, and centers gained by having access to more adolescents, particularly males (through sports team physicals) than did their counterparts with free-standing health centers.

The pilot study revealed a number of interesting issues that helped guide the research design of this multiple-site case study. Since all three sites in the pilot study were clustered at the voluntary end of the continuum of interaction, I recognized the need to examine an additional school-based health center whose

formal relationship with the school was closer to the mandated end of the continuum (Bogdan & Biklen, 1982). Inclusion of this type of site in the current study has allowed me to examine and contrast the effects that a power relationship had on the interorganizational relationship and the collaborative process between the school and the center, as opposed to those sites at the voluntary end of the continuum of interaction.

I examined the various forms of collaboration at each site, focusing on the day-to-day working relationships of each school and health center. My goal was to look closely at the practices of the organizations at each site in order to begin development of a practical, working definition of effective interagency collaboration. Thus, the findings of this pilot study became integral to the multiple case study. In addition, I chose to include two of the pilot study sites in the full study, offering added opportunities for more in depth study of those two pilot sites.

Methodology

The qualitative case study approach was well suited to this multiple-case analysis of the challenges faced by school-based health centers and their host schools as they endeavored to make interagency collaboratives work in schools. Merriam (1988) states, "The decision to focus on qualitative case studies stems from the fact that this design is chosen precisely because researchers are interested in insight, discovery and interpretation rather than hypothesis testing" (p.10). The multiple-case studies conducted were clearly concerned with insight --- what do we need to know about how collaboration works? --- discovery - how do schools and clinics actually collaborate? --- interpretation - what implications do the findings hold for future interagency collaboratives?

The three sites in the study displayed both similarities and differences in their sponsoring agencies, major funding sources, services offered, and location on

the continuum of interaction. Two exemplified Levine and White's interorganizational exchange theory, while the third, fell closer towards March and Simon's power dependency theory, prompting my label, mandated collaboration. Yin (1984) notes, "The evidence from multiple cases is often considered more compelling, and the overall study is therefore regarded as being more robust" (p. 53).

To answer the research questions of these multiple-case studies, I used three different sources of evidence: documents, open-ended interviews and direct observation. Used in combination, these multiple sources of evidence served to maximize their strengths, while minimizing their weaknesses (Merriam, 1988; Yin, 1984).

Document Review

I reviewed public documents including sponsoring agency literature; clinic program documents such as pamphlets, registration forms, flyers, evaluations, medical protocols, and newsletters; school memoranda (internal, i.e. meeting agendas and external, i.e. newsletters); district documents, including applicable policies, and notices; newspaper clippings and magazine articles. These documents were used to corroborate and augment evidence from other sources (Yin, 1984).

Interviews

As one of the most important sources of case study data (Yin, 1984), I conducted thirty-one focused, open-ended interviews of twenty-four respondents. To insure confidentiality, I disguised the names of all sites and assured interviewees that their anonymity would be maintained and that I would not share any information given with another respondent. I modified the interview guides in three ways to make them appropriate for health center staff, district and school administrators, and teaching staff. I fully utilized the open-ended nature of the interviews, including the possibility of some respondents becoming key informants,

offering valuable insights, and possible "sources of corroboratory evidence" (Yin, 1984, p. 89).

Interviewees included school personnel - principals, assistant principals and housemasters, guidance counselors, and teachers; superintendents and other district administrators; health center staff, including center managers, family nurse practitioners, medical directors, counseling social workers, school nurses, and nutritionists; sponsoring agency directors and program liaisons. I remained open to suggestions for additional potential interviewees and interviewed several persons who were recommended.

Direct Observations

"By making a field visit to the case study 'site', an investigator is creating the opportunity for direct observations...such observations serve as yet another source of evidence in a case study" (Yin, 1984, p. 91). These direct observations took place as Yin suggested, on site visits while collecting documents and conducting interviews and were documented in my field notes. Since two of the case study sites were those previously investigated in my pilot case study, I used those early observation notes along with notes of the new observations, while I remained open to further corroboratory evidence as well as possible contradictory evidence.

Data Analysis

My overall analytic methodology employed a strategy that Lofland (1971), Murphy (1980), Yin (1984), Merriam (1988) and Marshall and Rossman (1989) acknowledged as part of case study research, which was to collect data and conduct analysis concurrently, while the deepest analysis transpired while writing the chapters on the three major challenges.

I used three methods to analyze the data collected. First, I listed all the areas and topics that needed to be identified across the sites and positions of interviewees. I then used a combination of color markers and highlighters to

topically code all interview transcripts, documents, and fieldnotes. I coded them as Miles and Huberman suggested, using single terms and names that were close to the concept's description, such as school name, position of staff member, and theme or concept. Sub-categories such as communication, center services, and differences between disciplines were incorporated into the folders of one of the three main categories: relationships, confidentiality, or referrals. Categorizing the evidence in this manner facilitated my search for patterns across the sites and possible emergent themes, and allowed similarities and contrasts to clarify the data for further analysis.

Second, I wrote numerous analytic/reflective memos (Bogden & Biklin, 1982), at different stages of my research, keeping in mind that they were to be "conceptual in intent" (Miles & Huberman, 1984, p. 69). I used these memos to raise my thinking above the data to the conceptual level to assist in synthesizing and refining ideas. These analytic memos were invaluable as a method for clarifying my concepts, perceptions, and images.

Third, since I was the sole researcher of these multiple-case studies, I shared my numerous drafts with my advisor and committee members, colleagues, fellow researchers and interviewees, as a check on issues of validity and researcher bias, to address possibilities of rival hypotheses, and to critically question my analyses (Yin, 1984; Merriam, 1988).

Findings

Three major challenges arose for respondents in the study in their quest to make their school-based health centers work for students and their families: developing and maintaining relationships, maintaining confidentiality, and managing the referral process.

Building and Maintaining Relationships

The issue of relationships surfaces wherever people work together, inasmuch as relationships lie at the core of interpersonal interaction. Interpersonal interaction, both formal and informal, rose to prominence in the development, implementation, and maintenance of school-based health centers. Interviewees found styles of communication and developing and maintaining relationships critical to the "socialization" process of integrating the health center into the school. This task of integrating two usually autonomous organizations under the roof of the host organization became more complex because the issues of human relations, social interaction, and individual relationships now became major matters of *interorganizational* concern.

Health center staff encountered challenges to building internal and external interaction relationships. Internal relationships concentrated on matters specific to the workings of the health center, such as management procedures, health protocols, and services. External relationships focused on interactions with everyone else: the school, sponsoring and funding agencies, and the community. Although these two categories, internal and external relationships, seemed relatively simple, they became more complex when it was discovered that both included formal and informal interactions. Formal interactions involved policy and governance issues, and informal interactions, involved personal, one-to-one interactions. The external relationships that had to be built with school faculty and administrators, parents, the community, and with the students themselves caused health center staff the most concern and consumed a great deal of their time and attention.

Significantly, over time, approaches for dealing with policy and governance issues, such as under whose jurisdiction a particular situation falls or who could be notified regarding a confidential matter, became *internalized* by both staffs. This process allowed trust to be established which permitted both staffs to work at the

most important informal interaction level, person-to-person, freeing them to focus their energies on resolving the situation at hand.

When school personnel and center staff were able to develop informal, one-to-one relationships, the result was the ability to collaborate on a day-to-day basis. Consequently, I offer this working definition of effective day-to-day collaboration:

> *Effective day-to-day collaboration occurs when interacting parties have developed one-to-one relationships and internalized the rules and regulations governing the collaborative partnership thus allowing them to fully focus on the best way to resolve a particular problem involving a student's situation without concern for their own power, authority or domain.*

Day-to-day collaboration became an "operative mind set" that all parties involved began to *incorporate* into their daily activities. When a student presented a problem, both school and center staff members approached problem-solving in a more personalized and efficient manner, enabling the student's well-being and best interests to become the focal point of all interactions.

In order for the great potential of school-based collaboratives to be realized, the multi-faceted challenges of building and maintaining relationships must be acknowledged, understood, and then acted upon so that day-to-day collaboration can take place. When this occurs, interagency collaborations have the opportunity to positively affect the lives of students and their families in ways that the organizations functioning separately, offering fragmented services, cannot.

The Referral Process: Different Rules for Different Schools

The second major challenge, the referral process, is more circumscribed than building relationships. It is a tangible activity in which the official exchange of information about students takes place. In order for this exchange of information to

occur, those who refer students to the health center, teachers, administrators, guidance counselors, parents, and the students themselves must be comfortable with the guidelines set up for this purpose. Thus, flexibility is a key component of an effectively developed referral process. The more flexible the referral process, the more comfortable students, faculty, and parents will feel in approaching and using the center's services. Together, the school and health center should offer as many options as possible for students to be referred to the center. Having options reflects a respect for those involved and a less authoritarian climate that allows students to feel empowered.

For a school-based health center to be successful, the importance of communication between staffs cannot be overemphasized. Time and care should be taken by health center staff to explain the services of and need for the school-based health center to school personnel. Health center staff must be prepared to frequently discuss with teachers the tremendous need adolescents have for mental health care so that school personnel will cooperate in getting help for students in need by referring them to the health center. School personnel are more aware of the impact that poor physical health can have on a student academically than the impact or even the existence of a mental health problem. These explanations and discussions between school and health center staff (as opposed to memoranda and announcements) may make the critical difference between students with mental health needs getting care or not, by circumventing, as one site experienced, the reluctance some teachers may have towards making mental health referrals.

Confidentiality: An Issue of Trust

It is important for collaborators to know that the issue of maintaining students' confidentiality will arise and that it has potential for creating major problems. Therefore, discussions on the issue should begin in the planning stage of the project, well before implementation. The collaborators should understand also

that the basis for the misconceptions on confidentiality lies in philosophical differences between the disciplines of education and health care, and that while confidentiality is a major tenet in health care, its total opposite, sharing information, is a major tenet in education. Once clarified, the two staffs can begin a dialogue that will allow them to come to a working agreement regarding student confidentiality issues.

Equally important, health center respondents repeatedly asserted that if students' confidences were not kept, students would not come to the health center at all. Health center personnel worked hard to devise strategies that bridged the gap between school staff members' "desire to know" and their own staff members' "desire not to tell". Interviewees disclosed five categories of maintaining confidentiality: (1) *sharing confidences* - instances where the student gives permission to share information; (2) *confidentiality without details* - school administrators came to a point where they were satisfied to know there was a "confidential situation", without having to know the details of the situation; (3) *confidentiality and school discipline policies* - when health center staff would often advocate for students in disciplinary hearings, using their knowledge of confidential situations; (4) *mechanisms for managing confidentiality* - such as having the teacher ask the student him- or herself, use of closure statements such as, "That's all that I can share...", having the teacher and student make the initial appointment at the health center together, and enlisting the school staff member in monitoring a student's progress from the in school/classroom interaction point of view, and (5) *special cases when confidentiality is not maintained* - suicide ideation and weapons, which were handled similarly across the sites, and teen pregnancy, about which policies varied across the sites regarding parent notification.

In all, the confidentiality issue is a difficult one to traverse. Those schools and health centers that put forth the effort to resolve the differences they encounter

are more likely to have health centers that will be frequently utilized by students. Students' voluntary use of services depends on the respect they receive from health center staff members' maintenance of their confidences, which the students are entitled to.

In addition to these three major challenges, another issue of central importance emerged during the study: *the differences between the disciplines of health care and education.*

Differences between the disciplines of education and health care require attention from both the collaborators and implementors. One reason is that these differences underlie and connect the three major challenges previously discussed. Early in the collaboration as relationships began to develop, differences surfaced in the areas of: discipline and suspension matters, the issue of students' time out of class for appointments at the center, and conflicting priorities which sometimes pit a student's health against his or her academic work.

The confidentiality area is where the differences between health care and education are clearest. Maintaining a confidence and sharing information definitely fall on opposite ends of the disclosure continuum. To compound matters, the two opposing philosophies are major tenets of the two professions and can even cause legal problems for school systems if certain confidentiality mandates are not adhered to. In addition, it is important to note that these differences belong in part to the belief system of the discipline, which have become embedded in the practices of both staffs, through training and professional culture. As a result, people often think and act without conscious consideration of their thoughts and actions. With the referral process, the difference lies in the fact that referrals are a necessary and respected tool in health care, while usually used in only severe instances in schools. This fact was evident at one site where teachers were extremely reluctant to make mental health referrals for the first year and a half of their collaborative.

Consequently, the matter of differences between disciplines is one that should be taken seriously. Careful consideration by those involved in planning and implementing interagency collaboratives must be given to allow for ongoing discussions and clarifications of when and where these differences may interrupt or block progress of the collaboration.

Interprofessional development is one way to address these differences between disciplines. One of the six "compelling conference themes" of the fall 1994 Working Conference on School-Linked Comprehensive Services for Children and Families was entitled "Interprofessional Development". A long-range strategy designed to combat the kind of professional fragmentation that differing goals, separate coursework, and different professional terminology can have on services to youth and families, interprofessional development is considered one way to prepare professionals to participate in and successfully direct collaborative projects. Kirst (1991) suggests, "Universities have a major role in designing interprofessional preparation through interprofessional courses, continuing education, and interprofessional policy analysis" (p. 617). If interprofessional development is, as the Working Conference cited, "as inevitable as collaborative services", (AERA, 1995, p. 14) it warrants continued attention and evaluation, and broader implementation than the few interdisciplinary programs that currently exist.

Implications

Reflections on the findings of this study led me to review the relevance of bureaucracy theory as described by Michael Lipsky in his now classic text, Street-Level Bureaucracy (1980). He noted that, "legislative initiatives to limit [federal], state, and local spending have largely been understood as attacks on governmental performance and the ineffectiveness of social services" (1980, p. xv). Interagency

collaboration came out of this reform climate that demanded fiscal efficiency, and imposed a shift in bureaucratic attitudes that placed demands on service agencies such as schools, social services, and housing to work together in order to "do more with less". Lipsky's analysis of the policy alternatives is still apt today: "When all the 'fat' has been trimmed from agency budget[s] and all the 'waste' eliminated, the basic choices remain: to further automate, systematize, and regulate interactions between government employees and citizens seeking help; to drift with the current turmoil that favors reduced services and more standardization in the name of cost effectiveness and budgetary controls; or to secure or *restore the importance of human interactions* in services that require discretionary intervention or involvement" (p. xv). [Emphasis added] Building relationships, maintaining confidentiality, and elements of the referral process all revolve around the concept of human communication. The "humanization" aspect inherent in this process is grounded in the person-to-person communication exemplified by day-to-day collaboration. The focus on communication and bottom up reform may become the content of a paradigm shift in bureaucratic values and resulting policy and practice. When there is top-down support for such initiatives their potential for success is maximized.

I believe that this movement may tentatively establish a basis for what I would call a "humanistic efficiency model" of human service delivery. In contrast to traditional bureaucratic practices as described by Lipsky, putting people first in human service delivery moves the focus from a desk-to-desk orientation, to a person-to-person orientation.

The following are five recommendations that, when viewed individually were not found to be as important as the major challenges, but together formed a group of circumstances that strongly impacted the collaborative ventures in this study.

First, consideration should be given to the importance of the role counseling social workers play in these comprehensive health centers. The existence of the

school-based collaborative that brought the health centers to these schools was itself responsible for the discovery of the unmet need for counseling services by the regular education student population. All comprehensive school-based health centers studied here provide (or provide access to) mental health services. Other school-based collaboratives, like juvenile justice and youth services initiatives could presumably provide mental health counselors as well. Considering the crucial need in this area, interagency collaborators should look closely into the possibility of including counseling or clinical social workers in the services they plan to provide.

Next, the study revealed the counseling services that clinical social workers provide cannot be labeled according to presenting the "problem", such as drug or alcohol abuse, or victims of violence or rape. When they are labeled in this way, students will not participate because they do not wish to be publicly identified with the particular problem. Titles of group counseling sessions should be broad and encompassing, such as one site's "Choices" counseling program, for example.

Third, an advisory board or council with a broad representative base must be established to support the health center. Interagency collaborative ventures require the community support and credibility that such a council can provide. It will serve a number of needs and purposes at the pre-planning, planning, implementation, and maintenance stages of the collaborative. It can provide credibility with the community, serve as a sounding board for ideas, and offer guidance and constructive criticism to planners. Throughout the life of the collaborative it should remain active, meeting as often as necessary (frequently in the beginning), and no less than twice annually.

Fourth, key members of the school-based program should meet with the principal and his/her administrative team regularly. Center staff reported having access to the principal when necessary, but most missed the regularly scheduled meetings held in earlier stages of the collaborative. Time is a scarce commodity in

schools, and as one supervisor admitted, "We're 'meetinged' out here", so these meetings should be purposeful and efficient. The meetings are important to keeping the lines of communication open and flexible, and keeping everyone informed on health center matters.

Last, yet most importantly, school-based health centers must have consistent funding. No collaborative can expect to succeed if the partners have to constantly worry about the following year's funding. Their focus should remain on providing services to students and families and on resolving the challenges that they face daily. As we have seen from past experiences, our society will either pay for these problems now with preventative programs or pay later, with higher costs in health care, incarceration and loss of human capital. In these tough economic times, interagency collaboratives save money as they share locations, security, and other essentials. Many school-based interagency collaboratives have been shown to be cost effective (Dryfoos, 1994; RWJF, 1993).

Another implication of the study involved the Continuum of Interaction. The earlier discussion of interorganizational analysis suggested visualizing the relationship between two organizations that are working together as falling on a continuum of interaction ranging from mandated to voluntary relations. At one end would be those relationships called "power-dependency", identified by March and Simon, and toward the other end, relationships would reflect Levine and White's exchange model of voluntary interaction (1961). In this study, two sites fell at the voluntary end, while the third, a mandated program, fell closer towards the involuntary end.

This third site actually represents a successful transformation of the power-dependency model because it contains a range of voluntary choices *within* the mandated structure itself. The state mandated the types of services the program must provide, while allowing the local community to decide which agencies and

organizations should provide those services. Thus, this program encourages local collaboration within a structure that maintains broad state mandated requirements that have been studied and chosen for their effectiveness.

I refer to this program as a model of "mandated collaboration" and I believe it holds promise for school-based collaboratives. In their Compact for Learning reform initiative, the New York State Education Department used a phrase that aptly describes this philosophy, which is "top down support for bottom up reform". States have more resources to study outstanding collaborative programs than do counties and cities, and they can use that knowledge to mandate broad parameters for state-funded collaboratives, hence, "top down support". This particular collaborative simultaneously represents "bottom up reform" in that local county collaborators were empowered to choose which agencies and organizations could provide the best services based on the locally determined needs of their community. At this point, the organizations collaborated *voluntarily*, providing a balance within the continuum of interaction, while remaining near the involuntary end. Hence, the term, mandated collaboration. The program, begun in 1988, has data that shows reduced pregnancy rates, reduced school suspensions, and yearly increases in students registered at the centers, in addition to improved school attendance rates. This is surely one program that deserves further inspection and research toward replication.

It was noted that, one major advantage of the mandated collaborative is its secure state funding. Another is the inservice staff development and access to resources that the state health department provides for program staff. It is interesting to note, however, regarding school to health center interactions, that there was little discernible difference between this site and the two centers located at the voluntary end of the continuum. I suspect that the voluntary aspects of the program affected staff interactions more than the broader, involuntary state mandates. As a result, program staff members could focus on resolving the

challenges of the collaborative without spending precious time worrying about funding. Early statistics on the state program's effectiveness support this successfully combined approach.

Conclusions: Interagency Community Schools

I fully concur with Joy Dryfoos' analysis of the burden schools feel they are under:

> Today's schools feel pressured to feed children; provide psychological support services; offer health screening; establish referral networks related to substance abuse, child welfare, and sexual abuse; cooperate with the local police and probation officers; add curricula for prevention of substance abuse, teen pregnancy, suicide, and violence (the new morbidities); and actively promote social skills, good nutrition, safety and general health....They acknowledge that they cannot attend to all the needs of the current crop of students and at the same time respond the demands for quality education (1994, p. 5).

Clearly, schools cannot do the job alone. I believe schools are the place for health and social services to be placed alongside education. The complexities of life that students and families face today require more than the education that schools have traditionally offered and, as a result, in many instances, students cannot learn to their best abilities without the intervening assistance of health and social service providers.

Schools are not the only places for co-location of services for students and families. Some analysts, like Chaskin and Richman (1992) who offer a community-based model as an alternative to school-based models, express reservations about using the school as the primary context for interagency services. They cite institutional rigidity, the possible reluctance of the disenfranchised to

come into schools, and the questionable wisdom of schools taking on nonacademic tasks as reasons for placing integrated services outside of schools.

Still, most proponents of co-located services agree that schools are one of many sites where social, physical, and mental health services for youth and families can be brought together to better reach those in need. Kirst (1991) suggests, "Schools should constitute one of the centers of a coordinated network of total children's services" (p. 616). Of greatest importance, however, is that those who need these services most receive them in respectful, accessible environments.

The community schools model of the 1970's, which brought the concept of co-located services to life, has been recently updated into programs like New Horizons in San Diego, New Futures in Savannah, and the Children's Aid Society's Community Schools Program in New York, and possesses tremendous potential for eliminating some of the most pressing health, education, and social needs of students and families today.

Those who seek to implement school-based collaboratives need to keep in mind that schools are very closed systems, and although collaboratives, partnerships, and cooperatives are more common today, they are far from being the norm. The climate must be right, an advisory council must be in place, the community and school principal must support the project, and the collaborators must commit themselves to working through all the kinks of the program while maintaining respect for their colleagues' expertise and for the students and families they serve. School-based interagency collaborations hold great promise for improving the life chances and quality of life for students and their families.

Lest we forget that the focus of our efforts, students, have a voice of value that should be heard and respected, future research in this area should include their points of view. With them in mind, I close with a quote from one of the key informants in this study, a health center manager and family nurse practitioner:

> I think the greatest thing in the end about being in school, may not be what we have done for the kids, I mean, that's been good, but [better is] *what the kids have taught us about what they need.* Because you come in with a lot of assumptions....The issues are not giving birth control versus not giving birth control, and *you don't know that until you* ***listen*** *to the kids.* [Emphasis added]

Perhaps we can learn how to be of greater service to young people and their families by working collaboratively while taking the time to listen to those we seek to serve.

SCHOOL-BASED HEALTH CENTERS:
INFORMING FUTURE SITE-BASED INTERAGENCY COLLABORATIVES
Virginia L. Mayo Hardy, Ed.D.

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